

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-025708

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 318

Primary Registration District No. 1003 Registrar's No. 6277

STATE FILE NUMBER

VS-300
Rev. 4/59

1

2 205

3

4 2

5 0

6

7 1

8 1

9

10

11 000

12 77-3

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. STREET ADDRESS (If outside, give location) 5329 Bartmer Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Buchanan		4. DATE OF DEATH Month Day Year June 8, 1963	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/23/1942
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11a. BIRTHPLACE (City and state or country) Mississippi		11b. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Robert Buchanan		13b. MOTHER'S MAIDEN NAME Josephine (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		17. INFORMANT Address Robert Buchanan, Matthews, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture dislocation of the neck resulting in Paralysis. This was responsible for the decubitus areas with marked Sloughing - this resulted in a massive Proxistity. Suffered in fall from window at 5329 Bartmer on December 29th, 1962.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Accident			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See Above		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year ? 12-29-62	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
20f. CITY, TOWN, OR LOCATION St. Louis, Mo.		COUNTY STATE	
21. I attended the deceased from _____, to _____, and last saw her/him alive on _____. Death occurred at 3:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul J. Simon Deputy		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 6-13-63		22d. LOCATION (City, town, or county) (State) New Madrid, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-14-63	
23c. NAME OF CEMETERY OR CREMATORY Fannie Pyle Cemetery		23d. LOCATION (City, town, or county) (State) New Madrid, Mo.	
24. FUNERAL DIRECTOR ADDRESS DeLisle Funeral Home, Portageville, Mo.		25. DATE RECD. BY LOCAL REG. JUN 13 1963	
26. REGISTRAR'S SIGNATURE Paul Smith M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Harvey Kahle

Licensed Embalmer No. _____

4596

P. O. Address _____

St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.